treatment records should minimize the costs of the medical aid. However, it is also necessary to consider the cost of the effect achieved and quality price of not only the medical aid itself but the life quality to be created as a result of medical intervention. The latter fact is closely connected with the ethical and moral aspects of the medical aid. It predetermines the obligatoriness and the content of the informed patient's consent to medical intervention that must be a component of the patient's treatment record. Using the results of the pharmacoeconomic investigations and meta-analysis that must cover not only pharmaceutical facilities but also the other diagnostic may solve the described problems and therapeutic services as well. When developing such a system, it is necessary to consider the difficulties that may arise as a result of Russia's current practice to widely use the low-informative methods of diagnostics, low-efficient medicinal preparations, methods of physical therapy, and the unavailability of medical information for the patient.

PPR4

DEVELOPING METHODOLOGICAL STANDARDS IN PHARMACOECONOMIC RESEARCH: AN APPROACH BY A TASK FORCE OF THE AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY

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Pharmacoeconomic studies are increasing in number along with their use in healthcare decision-making. The methods and analyses used in these studies are often new to clinicians; thus, clinicians may often find it difficult to read, interpret, assess, and use these studies in their own decision-making when comparing products.
OBJECTIVE: In late 1997, the American College of Neuropsychopharmacology (ACNP) convened a task force charged with developing methodological standards that could be used to evaluate CNS-related (e.g., psychiatric, neurologic) pharmacoeconomic studies and be used to rate these studies.
METHODS: The Task Force was comprised of members of the ACNP, non-ACNP scientists, and representatives of the pharmaceutical industry with expertise and interest in pharmacoeconomics. The Task Force first compiled a draft set of rating criteria from existing criteria and other guidelines for pharmacoeconomic studies. Two separate rounds of feasibility tests were conducted during which Task Force members evaluated three pharmacoeconomic studies using the initial and the revised rating scale.
RESULTS: To date, a working rating scale using a 6-point Likert-type responses has been developed which includes 29 aspects of a pharmacoeconomic study over the following seven domains: scope of study, study objectives, sample, methods, definitions, results and discussion, and conclusions. The scale is under consideration for use by the ACNP pending further refinement.
CONCLUSIONS: A rating scale has been developed by which to assess pharmacoeconomic studies within a clinical specialty area. Further testing is needed to refine the scale and assess its psychometric properties.

PPR5

ESTIMATING HEALTHCARE COSTS IN THE ABSENCE OF FINANCIAL DATA: A CASE STUDY

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Patient-level healthcare costs are frequently estimated using claims databases or financial records (e.g., hospital bills and institutional cost reports). However, in some healthcare settings, particularly staff model HMOs, this information is absent.
OBJECTIVE: To develop a methodology for estimating costs of healthcare services in the absence of financial data at a staff-model HMO, using the Asthma Outcomes Registry as a case study.
METHODS: The Asthma Outcomes Registry compiled clinical and economic data on individual asthmatic subjects from three US managed care sites. Two sites provided data on utilization and cost of healthcare services derived from health insurance claims. The third site, a staff-model HMO, provided data on service utilization but not cost. We used claims data from the two sites that provided it to impute unit costs of services for treatment of asthma and allergic rhinitis at the third site. Analysis of covariance models were fitted to the logarithm of cost per encounter (or per inpatient day) for patients with such data, and these models were used to assign a cost (retransformed logarithm) to each healthcare encounter at the staff-model HMO. To preserve variation, each encounter's cost was drawn randomly from the distribution (mean and variance) estimated from the other two sites.
RESULTS: Estimated geometric mean costs (logarithms ± standard error) of outpatient encounters for asthma and allergic rhinitis were \$78.26 (\$4.36 ± 0.014) and \$66.02 (\$4.19 ± 0.032), respectively. Corresponding estimates for emergency visits and inpatient days for asthma were \$208.51 (\$5.34 ± 0.059) and \$820.57 (\$6.71 ± 0.092). Visits for allergy testing were estimated to cost \$25.03 (\$3.22 ± 0.009).
CONCLUSION: Diagnosis-specific unit costs of medical encounters can be imputed in settings where such data are absent using data from comparable settings.

PPR6

COST-EFFECTIVENESS ANALYSIS: A SIMULTANEOUS MARGINAL-EFFECT APPROACH

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